CONSENT TO USE AND DISCLOSURE IF HEALTH INFORMATION

PATEINT NAME: LAST_____FIRST_____MIDDLE_____

SOCIAL SECURITY NUMBER_____DATE OF BIRTH _____

I UNDERSTAND THAT AS PART IF MY HEALTHCARE ORGINATES AND MAINTAINS HEALTH RECORDS DESCRIBING MY HEALTH HISTORY, SYMPTOMS, EXAMINATION AND TEST RESULTS, DIAGNOSIIS, TREATMENT AND ANY PLANS FOR FUTURE CARE OR TREATMENT. I UNDERSTAND THAT THIS INFORMATION SERVES AS:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party can verify that series billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I acknowledge that I have been provided with a *Notice of Privacy Practice* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I am revoking this consent in writing, except to the extent that the organization has taken action in reliance thereof. I understand that if I have questions or complaints I may contact the Privacy offices on the *Notice of Privacy Practices.*

SIGNATURE OF PATIETN LEGAL REPRESENTATIVE:_____

REALATIONSHIP:_____DATE:_____

SIGNATURE OF OFFICE REPRESENTATIVE:_____DATE:_____